# Investigation into the death of a man whilst in the custody of HMP Leeds at Leeds General Infirmary in July 2010

**Report by the Prisons and Probation Ombudsman for England and Wales**

**November 2011**

This is a report into the death from natural causes of a man at Leeds General Infirmary whilst a prisoner at HMP Leeds. He was 76 years old. I offer my sincere condolences to his family for their loss. I apologise for the delay in issuing the report and any additional distress this may have caused.

The investigation was led by my one of my investigators. I must thank Leeds Community Primary Care Trust (PCT) for the appointment of the clinical reviewer. I am also grateful to the Governor and staff of HMP Leeds.

The review of the man's clinical care shows that he received good quality care whilst in Leeds. He had serious health problems, with a history of chronic obstructive pulmonary disease (COPD) and diabetes. Both these conditions were well managed at Leeds, with appropriate investigations and treatment.

My report contains two recommendations. One relates to an occasion when there was a delay in reviewing the results of a chest x-ray. Although this did not adversely affect his health I agree with the clinical reviewer's findings that systems are improved to prevent any repetition. I also make a recommendation that Leeds demonstrably promotes smoking cessation services to prisoners even when they have previously declined this service.

The version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

**Thea Walton**
**Acting Deputy Ombudsman** **November 2011**

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## SUMMARY

1. At the time of his death, the man was 76 years old and serving a twenty year sentence at HMP Leeds.

2. The man first arrived at Leeds on 1 August 2008. He had two long standing conditions affecting his lungs and general health, for which he took various types of medication and an inhaler. Whilst at Leeds, he was admitted to hospital on two occasions as an emergency patient. He was last admitted on 19 August 2009 when he was treated for a chest infection, increased breathlessness and weight loss. Following each admission, he was discharged from hospital and returned to prison.

3. He was given a follow up assessment by the community respiratory team in early September 2009 and advice was given regarding his use of inhalers. In September 2009, following treatment and due to his weakening condition and inability to cope on the wing, it was decided that the man should be moved to the healthcare inpatient unit. He remained in this unit until his death.

4. From October 2009 to May 2010, his lung condition deteriorated although he remained reasonably stable for the latter part of this period. During this time he underwent a series of further scans and tests at local hospital facilities partly due to his difficulties in swallowing. The results of these tests did not indicate any additional serious disease.

5. By late May 2010 he was observed to be struggling with his lung condition and increased breathlessness. He had for some time been using nebulisers as well as his inhaler, and required occasional additional oxygen.

6. In the early morning of 9 July 2010, a Healthcare Officer (HCO) was undertaking routine observation checks of prisoners, when he found the man collapsed in his cell. The HCO used his radio to issue an immediate call for emergency medical assistance and then entered the cell. He found that the man was not breathing. Uniformed and clinical staff responded quickly to the HCO's call for assistance. Using the defibrillator (a machine that applies electrical impulses to the heart and advises whether there is any rhythm which might be stimulated) the clinical staff found there was no shockable rhythm, so continued with resuscitation and gave oxygen. Paramedics arrived swiftly and, maintaining resuscitation, the man was transferred to Leeds General Infirmary Accident and Emergency department. Resuscitation was continued for a further ten minutes but, after finding no signs of life, the hospital doctor pronounced the man dead at 6.44 am.

7. My investigation found the man to have received a high standard of care at Leeds. However, I do make two recommendations for improvements that should be made. These relate to following up on test results and promoting smoking cessation.

## THE INVESTIGATION PROCESS

8. The investigation was opened on 9 July 2010 by one of my investigators. Notices were issued to staff and prisoners announcing the investigation. The notices included an invitation to those who wished to submit information on the man's death to make themselves known to the investigator. No staff or prisoners came forward as a result.

9. The investigator visited Leeds on 13 July. She was given access to all relevant prison records relating to the man. They included his prison record, medical records and statements made by staff.

10. Leeds Primary Care Trust appointed the clinical reviewer to carry out a review of the man's clinical care. My investigator discussed aspects of the man's treatment with healthcare staff at Leeds and with the clinical reviewer. The clinical reviewer told the investigator that having reviewed the man's medical record he did not need to conduct formal interviews with staff.

11. My investigator contacted Leeds Coroner's Office on 29 July and requested a copy of the post mortem report. The report was sent to the Ombudsman's office on 23 November.

12. My senior family liaison officer wrote to the man's wife on 2 August 2010. She also wrote to his friend and executor of his estate on the same day. The letters informed them of the opportunity to raise questions and concerns for the investigator to consider. There has been no response from either the man's wife or executor. A copy of my report will be made available to the family on completion should they wish to read it.

13. My report was issued in draft to the man's family and to the National Offender Management Service (NOMS). The man's family did not make any comments in response to the draft report. NOMS' responses to my recommendations are also included at the end of this report.

## HMP LEEDS

14. HMP Leeds is a category B local prison. The prison serves Magistrates' and Crown Courts in the West Yorkshire area taking adult male prisoners on remand until trial and for short periods after sentence. Up to 1154 prisoners are held on six wings and the healthcare centre in accommodation certified normally to hold 829 prisoners.

15. Healthcare staff are available in Leeds 24 hours a day. By day, there is a doctor in the prison; at night, cover is provided by nursing staff. There is a nineteen bed inpatient unit which is located directly above the main healthcare department. The unit is staffed by prison and clinical healthcare staff. Primary healthcare staff at Leeds prison are commissioned and provided by Leeds Community Primary Care Trust.

16. The most recent inspection by Her Majesty's Chief Inspector of Prisons was undertaken in March 2010. This was an unannounced follow up to an earlier inspection which took place in December 2007. None of the issues raised in that report are relevant to the circumstances of the man's death.

17. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The most recent annual report published by the IMB for Leeds does not contain any specific issues which need to be reflected upon here.

18. The Ombudsman became responsible for investigating all deaths in prison from 2004. Since that time there have been 18 deaths from natural causes at Leeds, including that of the man. There are no apparent similarities between either the circumstances of the deaths or the recommendations made.

**KEY EVENTS**

19. The man was born in Halifax on 6 January 1934. Prior to being sentenced he lived in Halifax with one of his daughters. He had a history of chronic obstructive pulmonary disease (COPD). This is a severe respiratory condition mostly caused by long term smoking. He also suffered from type 2 diabetes. Prior to being sentenced he was under the care of his doctor in the community for his medical conditions.

20. On 14 May 2008, the man was convicted of a number of serious offences. He was sentenced on 1 August 2008 to twenty years imprisonment. He had no previous convictions and this sentence was his first experience of prison.

21. Before the man left Bradford Crown Court the dock officer completed a form recording his sentence to accompany him to the prison. On this form the Dock Officer also recorded "inhaler on person – very bad health – maybe not long to live".

22. On his arrival at Leeds, the man underwent a healthcare assessment during the reception process. Nurse A recorded that he suffered from asthma and diabetes, and the medication that he was currently taking. The screening indicated that the man should be held on the vulnerable prisoner unit, and was unfit for work. The man indicated he wished to see the doctor for a prescription of his medication and said that he "felt chesty". During the healthcare assessment he was identified as a smoker and asked whether he wished to quit. The man's response was that he did not wish to do so. He continued to smoke up until his death.

23. An appointment was made for the man to see a doctor the following morning. In the meantime, he was prescribed his current medication. He was then transferred to A wing, which is Leed's vulnerable prisoners' unit[1].

24. Prison Doctor A saw the man on 2 August and diagnosed Chronic Obstructive Pulmonary Disease (COPD) and type 2 diabetes. The doctor prescribed an inhaler and some antibiotics. This was in addition to medication already prescribed. Healthcare staff requested the man's medical history from his GP which was received by fax on 5 August. The following day the man was seen by prison Doctor B for a review of his medication.

25. On 2 September 2009 the community respiratory team assessment suggested that the man should be given smoking cessation advice. Subsequently, prison Doctor B recorded that the man was a smoker and noted the health education issue

26. The medical records show that over the next ten weeks healthcare staff treated the man for two infections relating to his COPD. Due to increased breathlessness he was seen by prison Doctor C on 2 September and advised

[1] The vulnerable prisoner wing is a separate wing designed for prisoners who need to be separated from the main prison population for their own safety. This is usually owing to the nature of their offence.

about his use of the inhalers. He was prescribed a steroid and antibiotics. Prison Doctor B examined the man again on 9 October, and requested a chest x-ray. An appointment was arranged at the Leeds General Infirmary for the x-ray for 27 October.

27. On 20 October the records show that the man underwent a further examination by the prison Doctor B. As a result of this examination the man was moved to a lower landing on A wing due to difficulties he was experiencing in using the stairs.

28. The man was taken to Leeds General Infirmary on 27 October for his chest x-ray appointment. He returned to the prison the same day.

29. On 30 October the man was examined again by prison Doctor B. At this time the results of the man's chest x-ray had not been received by the prison. Prison Doctor B did not observe any increase in shortness of breath.

30. The man's medical record shows that a letter regarding the chest x-ray was received from the hospital on 15 November. The x-ray results found that the man's lungs showed symptoms consistent with someone who was suffering from COPD. The results also showed some sign of infection and a follow-up appointment was suggested for six weeks time. There is no record of these results being reviewed by a member of healthcare staff. The man continued to be issued with repeat prescriptions for the following two months.

31. On 21 January 2009 the man was seen by Nurse B because he was experiencing muscular pain in his shoulders and arms. He was also having trouble sleeping. An appointment was arranged for him to see the doctor on 2 February.

32. During his appointment with prison Doctor D found the man's right wrist to be swollen and that he was suffering from stiffness in his shoulders with limited movements. The doctor also reviewed his chest x-ray report. This showed that the man was suffering from COPD and had a probable infection. It indicated a need for a repeat x-ray in six weeks time. The man's blood was also taken the results of which were considered normal. He was prescribed a pain killer.

33. A CT scan of the man's chest was requested on 6 February. A CT (computerised tomography) scan is an enhanced form of x-ray used as a supplement to normal x-rays as it yields more information.) This scan took place at the Eccleshill Treatment Centre, Bradford on 16 February. On the morning of his appointment, the man was seen by Nurse C because he was complaining of headaches and general body pain. Nurse C gave the man some paracetamol.

34. The prison Doctor B reviewed the results of the CT scan on 19 February. The scan showed the presence of bronchiectasis, which is an abnormal widening of a lung airway. This condition is associated with COPD and can make the

sufferer more susceptible to infections. During the remainder of February and March the man's current medication was maintained.

35. The man was examined again by prison Doctor D on 7 April. He said that he was neither sleeping nor eating well. Prison Doctor D found that the man was underweight, and prescribed him Ensure Plus liquid[2]. Further blood tests were ordered, and he was reviewed again by prison Doctor D on 22 April. The man complained of persistent aching in his arms and this, together with the test results, resulted in the doctor prescribing him steroids for two weeks.

36. Prison Doctor D saw the man again on 11 May for a planned review. By this time he had successfully gained weight, was reporting much less pain and was feeling much better. The Ensure Plus liquid and the steroids were gradually reduced over the next months.

37. On 4 July, the man attended the healthcare unit with increased breathlessness and a possible chest infection. He was given a nebuliser (a device similar to an inhaler used to treat more severe symptoms by which medication is breathed in though a mouthpiece or mask) and antibiotic treatment, and checked on A wing later in the day. The following day the man was seen by Nurse D. He appeared brighter and did not complain about his breathing. On 6 July the man was seen by the locum doctor who increased his steroid dosage. Four days later, he presented himself again with breathing difficulties and complained of not being able to sleep. He was examined by prison Doctor B who prescribed different antibiotics.

38. On 13 July, Nurse E was called to the wing due to the man's breathing difficulties. He also complained of chest pain. The man was given nebuliser treatment which eased his breathing. However, his chest pain persisted. An emergency ambulance was called and the man was admitted to St James University Hospital in Leeds. Nurse F contacted the hospital ward during this admission, and was told the diagnosis was exacerbation of COPD. The man was treated with oral antibiotics and given some new inhalers.

39. The man returned to Leeds on 17 July. Over the next month he was seen by doctors and healthcare staff on nine occasions, both on the wing and in the healthcare centre. The primary concerns were continued breathlessness, chest infection, sleeplessness, and weight loss. On 19 August prison Doctor E referred the man for an emergency admission to the Leeds General Infirmary due to his chest condition and weight loss.

40. During his stay in hospital the man was treated for his chest infection and a series of other tests and CT scans were undertaken. Other than the COPD exacerbation no other problems were identified. The man returned to Leeds on 25 August.

41. The Community Respiratory Team made a post-admission follow up visit to the man on 2 September. A full respiratory assessment was undertaken, and

[2] This is a food supplement designed to assist weight gain.

suggestions made regarding his inhalers. A recommendation to the doctor to provide smoking cessation advice was recorded on the assessment form. The man is recorded as “feeling back to his normal level”.

42. On 18 September prison staff asked a member of healthcare to see the man in his cell on 18 September. The man was seen by healthcare officer. He said had been awake all night with vomiting and diarrhoea. The man was given some medication to ease his symptoms. Three days later he was seen by Nurse G in surgery who found him walking poorly, breathless, in low mood, and dehydrated. She considered the man was no longer fully able to cope being on the wing. It was decided to admit him into the healthcare inpatient unit on 23 September.

43. The man’s condition continued to deteriorate over the following weeks. Prison Dr B examined him again on 16 October observing that he continued to lose weight despite food supplements, he was suffering dysphagia (difficulty in swallowing), and was experiencing abdominal pain. Prison Dr B referred the man for a series of tests at the Leeds General Infirmary.

44. Between late October and December the man was taken to hospital for various scans on six occasions. None of these scans indicated any serious disease, although an inflammation of his stomach was identified for which he was effectively treated.

45. By the middle of November it was noted the man was regaining weight, though he remained frail. He was at this stage making use of both inhalers and nebulisers to counter the symptoms of his COPD, and he was given advice on how to use these most effectively. He continued to receive his regular medications, and was regularly reviewed by healthcare staff. On 12 December prison Dr B recorded that he was a “smoker-rolls own cigarettes-health education-smoking”, but it is not clear whether this means he was actually given smoking cessation education.

46. The man’s condition had settled to the extent that by 4 January 2010 Healthcare Officer B recorded him to be “very independent in all aspects of his daily living”. Over the next five months to May he was regularly described as being mobile and taking exercise in his cell or around the healthcare unit. It was also noted that he was “uncomplaining and self caring”. Despite these positive notes, it was also clear that the man continued to suffer from worsening breathlessness and received some occasional oxygen to assist with this.

47. During this period he had two further escorted visits to the Leeds General Infirmary, on 4 and 22 March. The first resulted in discharge from the care of the gastroenterologist dealing with his stomach inflammation, and the second was for the retinal scan required for patients suffering diabetes. This scan indicated his retinas were normal and that the man’s diabetes remained well managed.

48. On 7 March a formal five point care plan was written by the healthcare manager to manage the man's COPD and to promote his independence and well being. His medical records show that this plan was adhered to through to July.

49. Prison Doctor B saw the man on 27 May when he was observed to be "struggling" with his COPD. He was prescribed steroids and antibiotics which stabilised his symptoms within a few days.

50. In mid June the man was treated for a urinary tract infection. Regular nursing reviews through the remainder of June indicated that he was settled, and able to move around the unit. The last review on 27 June by Nurse H recorded the same and that the man had no complaints at this time.

**Events of 9 July 2010**

51. At approximately 5.50 am on 9 July healthcare Officer (HCO) D was undertaking a routine observation of prisoners in cells in the healthcare in-patient unit. Healthcare Officer D looked into the man's cell through the observation panel and he saw him collapsed on the floor. He called out to the man but did not receive any response. He used his radio to call for immediate assistance from other staff. The officer also alerted the night orderly officer, and the Senior Officer (SO), that he was breaking his sealed key pouch to enter the man's cell.[3] The prison control room incident log records that this call was made at 5.52 am.

52. Having entered the cell, Healthcare Officer D found the man had a slight laceration to his head, was not breathing and had no pulse. He therefore started cardiac pulmonary resuscitation (CPR) compressions, while waiting for other staff to arrive and assist. A few minutes later the SO arrived, and a few moments after him the first nurse on the scene arrived followed by the second nurse on the scene carrying the medical emergency bag. The first nurse on the scene gave the man breaths via a face mask, then applied the defibrillator.[4] The results of the defibrillator did not advise that an external shock was appropriate so CPR was continued. The second nurse on the scene gave the man oxygen while the first nurse on the scene and the SO took over giving CPR compressions.

53. The SO called for an emergency ambulance. The prison control room incident log records the SO's request at 5.56 am. The ambulance arrived at the prison at 6.04 am, and the paramedics entered the cell within a few minutes. The nurses briefed the paramedics who took over the CPR. The man was quickly transferred to the ambulance, with the nurses assisting to maintain the CPR. The control room log shows that the man was in the ambulance at 6.20 am.

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[3] At night time officers carry keys in a sealed to pouch which only be opened in the case of an emergency.

[4] A defibrillator is a machine used to shock the patient's heart and restore the heart's normal rhythmic patterns. It cannot however, restart the heart if a detectable rhythm cannot be found.

54. The SO asked Officer A and Officer B to escort the man to hospital, with appropriate instructions not to apply handcuffs. The control room incident log records that the ambulance left the prison at 6.26am. The ambulance arrived at Leeds General Infirmary at approximately 6.33am and clinical staff in the Accident and Emergency department continued resuscitation attempts. However, this was unsuccessful and the man was pronounced dead at 6.44am.

55. A post mortem was carried out at the Coroner's request. The doctor who carried out the post mortem found that the primary cause of the man's death was Ischaemic heart disease (an inadequate supply of blood to the heart muscle) due to atherosclerotic coronary artery disease (narrowing of arteries to the heart), with secondary causes as diabetes mellitus, hypertension and chronic obstructive pulmonary disease (COPD). The immediate cause of his death was a heart attack.

56. Healthcare Officer A was appointed as the prison's family liaison officer. At 9.35am on 9 July he together with Governor A, visited the man's wife at her home. The man's wife was given the news that the man had died. Later the same day he gave the same news to his friend, by telephone.

57. Over the next eight weeks Healthcare Officer A liaised with, and offered support, to the man's family. He had telephone contact with the man, two of her daughters, and two of her grandchildren. He also liaised with other professionals involved with the family, and with the Coroner's office and the man's solicitor.

58. Following the man's death staff were offered access to the prison's staff care and welfare team. The man's funeral took place on 6 August. The Prison Chaplain conducted the funeral service and the prison paid the full cost of the funeral in accordance with the guidance given in Prison Service Order 2510, Follow up to Deaths in Custody.

## ISSUES

### Clinical Care

59. A clinical review was undertaken by the clinical reviewer on behalf of Leeds Community PCT. The clinical reviewer concludes that it is likely the man had a well established disease of his coronary arteries at the time he was taken into custody and he was at risk of suffering a heart attack with its risk of sudden death at any time. He considers it probable that even had the man suffered his heart attack in the presence of healthcare staff or in a hospital the man would not have survived.

60. The man was known to suffer from COPD and diabetes at the point of his reception into Leeds. The clinical reviewer indicates that the treatments he was given for his COPD were all of a good standard, and that the infections that he suffered as a result of the disease were well managed. Similarly, he found that the man's diabetes was well controlled and monitored. In addition, the clinical reviewer considers that the new presenting symptom of difficulty in swallowing (dysphagia) was investigated in a timely and appropriate manner.

61. There is evidence that the results of the man's first chest x-ray were overlooked for a number of months until he presented with muscular pain requiring a further scan. The clinical reviewer does not consider this oversight was indicative of a frequent problem at Leeds and there was no negative consequence to it on this occasion. However, it is important that robust procedures are in place to follow up test results in a timely manner. I therefore endorse the following recommendation made by the clinical reviewer:

    **The Healthcare Manager at HMP Leeds should ensure that test and x-ray results are reviewed promptly by the appropriate member of healthcare staff.**

62. The clinical review also highlights the importance of smoking cessation advice. During his initial reception health screen the man was identified as a smoker and asked whether he wished to quit. The man's response was that he did not wish to do so. On 2 September 2009 the community respiratory team assessment suggested that the man should be given smoking cessation advice. Subsequently, prison Dr B recorded that the man was a smoker and noted the health education issue. It is not clear what action was taken. I agree with the clinical reviewer's recommendation and repeat it here:

    **The Healthcare Manager at HMP Leeds should ensure that smoking cessation advice is given to all smokers on a regular basis and that the outcome of this is clearly documented.**

63. Despite the issues highlighted above, the overall standard of care given to the man at Leeds was of a high quality.

## Emergency Response

64. Following the discovery of the man in his cell both uniformed and clinical staff responded swiftly and efficiently. Healthcare Officer D entered the man's cell and immediately summoned healthcare staff and an ambulance. He also began resuscitation procedures. Healthcare staff arrived quickly with the appropriate medical equipment. The emergency equipment was immediately applied to the man. The control room log shows that the ambulance took six minutes to reach the prison. On arrival the paramedics were quickly escorted to the man's cell where they started their own advanced life support procedures. The man was taken to the ambulance where escort staff were waiting. SO A gave the instruction that restraints should not be applied to the man in case he required further emergency medical intervention. The decision not to apply restraints was compassionate and appropriate in the circumstances. It also offered the man some dignity when he died.

## Conclusion

65. The man was a man in poor health whose medical needs were well served while at Leeds. The staff responding to his collapse acted with professionalism and consideration.

## RECOMMENDATIONS

1. The Head of Healthcare at HMP Leeds should ensure that test and x-ray results are reviewed promptly by the appropriate member of healthcare staff.

   Accepted- A new process now exists in healthcare whereby all diagnostic and laboratory results received in to healthcare at HMP Leeds are forwarded immediately to the GP are not scanned on to SystmOne electronic medical records until they have been reviewed and commented upon.

2. The Healthcare Manager at HMP Leeds should ensure that smoking cessation advice is given to all smokers on a regular basis and that the outcome of this is clearly documented.

   Not accepted- All prisoners are offered smoking cessation advice at screening reception and can access health promotion advice at any point during their stay. However, it is not possible within current resources for healthcare to undertake to regularly revisit this for every prisoner who smokes. In addition, evidence based practice in motivational interviewing for substance use would suggest that repeated information giving is more likely to be counter-productive rather than beneficial.